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I.D. TAG NO.
459
Local File NumberOREGON STATE HEALTH DIVISION
DEPARTMENT OF HUMAN RESOURCES
Vital Records Unit
CERTIFICATE OF DEATH

136-

State File Number

1. DECEDENT'S NAME First: <u>Leah</u> Middle: Middle Last: <u>MENEFFEE</u>			2. SEX <u>-Fe</u>	3. DATE OF DEATH (Month, Day, Year) <u>August 21, 1988</u>	
4. SOCIAL SECURITY NUMBER <u>540-26-4177</u>		5a. AGE - Last Birthday (Years) <u>83</u>	5b. UNDER 1 YEAR Mos. Days Hours Mins.	6. BIRTHPLACE (City and State or Foreign Country) <u>The Dalles, Oregon</u>	7. DATE OF BIRTH (Month, Day, Year) <u>August 1, 1905</u>
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
9a. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Residence <input type="checkbox"/> Other (Specify)					
9b. FACILITY NAME (If not institution, give street and number) <u>Albany General Hospital</u>			9c. CITY, TOWN, OR LOCATION OF DEATH <u>Albany</u>		9d. COUNTY OF DEATH <u>Linn</u>
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <u>Writer</u>		10b. KIND OF BUSINESS/INDUSTRY <u>Historical</u>		11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) <u>Married</u>	12. SPOUSE (If Married, Widowed) <u>Donald F. Menefee</u>
13a. RESIDENCE - STATE <u>Oregon</u>		13b. COUNTY <u>Linn</u>		13c. CITY, TOWN, OR LOCATION <u>Brownsville</u>	
13d. STREET AND NUMBER <u>35105 Union Point Lane</u>					
13e. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13f. ZIP CODE <u>97327</u>		14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:	
15. RACE American Indian, Black, White, etc. (Specify) <u>White</u>		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>2 yrs.</u>			
17. FATHER - NAME first middle last <u>Dr. H.C. Collins, MD</u>		18. MOTHER - NAME first middle maiden <u>F. Macnab</u>		19. INFORMANT - NAME and relationship to decedent <u>Donald F. Menefee - Husband</u>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>City View Crematorium</u>		20c. LOCATION - City or Town, State <u>Salem, Oregon</u>	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <u>Service M. Oedema</u>		21b. LICENSE NUMBER (Of Licensee) <u>0158</u>		22. NAME, ADDRESS AND ZIP OF FACILITY <u>Fisher Funeral Home, Inc., P. O. Box 156 306 SW Washington, Albany, OR 97321</u>	
TO BE COMPLETED BY CERTIFYING PHYSICIAN					
23. TIME OF DEATH <u>8:30 AM</u>		24. WAS MEDICAL EXAMINER NOTIFIED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) stated. (Signature) <u>Liana V. Barron</u>					
26. DATE SIGNED (Month, Day, Year) <u>8/22/88</u>					
TO BE COMPLETED ONLY BY MEDICAL EXAMINER					
27a. TIME OF DEATH <u>M</u>		27b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) <u>M</u>			
28. On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place and due to the cause(s) stated. (Signature)					
29. DATE SIGNED (Month, Day, Year) COUNTY					
30. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) <u>diana v. barron MD 439 no. main/pobox 218; brownsville OR 9732</u>					
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)					
32. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c). Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest.					
(a) <u>acute interstitial pneumonitis</u>					Interval between onset and death <u>5 days</u>
(b) DUE TO, OR AS A CONSEQUENCE OF:					Interval between onset and death
(c) DUE TO, OR AS A CONSEQUENCE OF:					Interval between onset and death
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I (a) <u>acute hepatitis, rheumatoid arthritis</u>					33. AUTOPSY <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
34. IF YES were findings considered in determining cause of death? <u>Yes</u>					
35. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined Manner <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		36a. DATE OF INJURY (Month, Day, Year)		36b. TIME OF INJURY <u>M</u>	36c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
36d. DESCRIBE HOW INJURY OCCURRED		36e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			
36f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
37. REGISTRAR'S SIGNATURE <u>Dawn R. Walker Deputy</u>			38. DATE FILED (Month, Day, Year) <u>August 23, 1988</u>		
39. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A			40. WAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A		
RESERVED FOR REGISTRAR'S USE					

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STATE OF OREGON
COUNTY OF LINNTHIS CERTIFIES THAT THE FOREGOING IS A REPRODUCTION OF A RECORD OF
DEATH ON FILE WITH THE LINN COUNTY HEALTH DEPARTMENTDawn R. Walker, Deputy
Deputy Registrar of Vital Statistics

Date

August 23, 1988

NOT VALID WITHOUT RAISED SEAL OF LINN COUNTY HEALTH DEPARTMENT